Colorado Department of Public Health and Environment

Medical Marijuana Registry

4300 Cherry Creek Drive South, Denver, CO 80246-1530 • 303-692-2184
E-mail: medical.marijuana@state.co.us • **Website:** www.cdphe.state.co.us/hs/medicalmarijuana

AP

Application Instructions

Colorado Medical Marijuana Registration Cards are available **only** for Colorado residents being treated for an active, chronic or debilitating medical condition. To apply for a registration card, please complete an application packet as described below. If you make a mistake, please complete a new form. **Do not write over, white-out or cross-out information. This will void the form.**

A complete application packet includes:

1. An Application for Registration Card completed by you, signed and notarized.
2. A Physician Certification completed by your doctor.
3. A copy of your Colorado ID. If you do not have a Colorado ID, submit proof of identity and Colorado residency.
4. A copy of your caregiver's valid ID and form **#MMR1012 Caregiver Acknowledgement**, if a caregiver is selected.
5. A form of payment or a Request for Fee Waiver/Tax Exempt Status form and supporting materials.

1. Medical Marijuana Registry Application

a. Please complete the entire application. **Write or type clearly** and neatly.

b. Patient Social Security Number: **Social security numbers are required** for application submission. The Registry uses a patient's social security number as a unique number for tracking records. Article XVIII, 14(3)(b)(II) of the Colorado Constitution states: "In order to be placed on the state's confidential registry for the medical use of marijuana, a patient must … submit the completed application form adopted by the state health agency, including the following information … (II) The name, address, date of birth, and social security number of the patient …" VISA/ITIN numbers are not accepted as a replacement for social security numbers.

c. Mark your application as 'NEW' if you have **never had a card** with the Registry. If you have had a card, regardless of the year, mark your application as 'RENEWAL.'

d. Submit renewal applications **between 45 to 60 days before your card expires** to allow time for processing. Renewal applications more than 60 days before the card expiration date are rejected as duplicate applications. Any fees sent with a duplicate application are non-refundable and are not credited toward future applications.

e. **Ensure the mailing address is complete, including apartment or lot number.** Mail returned to the Registry by the post office is retained for 90 days then shredded.

f. You may select to have a caregiver or a Medical Marijuana Center. It is not required to have either. **The provider will not be printed on your card, if provider information is incomplete or caregiver ID is not included.**

g. If you list a caregiver, you must also submit form **#MMR1012 Caregiver Acknowledgement and a copy of the caregiver's ID** with your application.

h. If you are under the age of 18 or homebound, you may choose both a caregiver and a Medical Marijuana Center.

i. Sign and date this form in front of a notary. The date of your signature and the notary's signature must be the same.

j. The form cannot be notarized by the patient, the caregiver, the physician or the person who signs the payment.

2. Physician Certification

a. Your physician must complete, sign, and date the physician certification.

b. The signing physician must be an MD or DO with an active Colorado medical license. Physicians with conditions or restrictions on their licenses, or out-of-state licenses, are not accepted.

c. The Registry must receive your complete, correct application packet within 60 days of the physician's signature. **Application packets with Physician Certifications more than 60 days old are rejected.**

d. The Registry cannot accept paperwork on security paper that reads "VOID" when copied.

3. Proof of Identity and Residency (see page 2 for Proof of Identity and Colorado Residency requirements) – **Please do not send the original document. Send a clear, readable and complete copy.**

a. Medical Marijuana Registration cards are available only to Colorado residents. You must provide proof of your identity and residency. Damaged, expired or tampered IDs are not valid.

b. The name on your application must match the name on your ID. If you have had a change of name since you last submitted paperwork to the Registry, provide a copy of the certified document proving name change (such as marriage license, divorce decree, or legal name change documents).

c. To ensure your ID is readable, please enlarge it on a copier at 150% to 200% and lighten background slightly.

4. Power of Attorney (POA) or Medical Power of Attorney (MPOA) Rights – If patient care has been legally assigned to another person, a copy of the notarized Power of Attorney or Medical Power of Attorney must be included with the application. A Medical Power of Attorney is required for an individual to consult with the Registry regarding the patients' records and care. A copy of the care provider's ID is also required.

5. Application packets must be sent separately. Only one application packet and check/money order per envelope. If sending by certified mail, certify each envelope separately.

6. **Please allow 4 to 6 weeks** from the date the Registry receives your paperwork for application processing. If you have not received a response within 6 weeks, please contact the Registry at 303-692-2184, ext. 3. Your paperwork or card will be mailed to the address on your application. The Registry does not mail cards outside of the state.
7. **DO NOT send** in any additional paperwork to support your application, unless requested by the Registry. Any non-required paperwork is shredded.

PROOF OF IDENTITY AND COLORADO RESIDENCY

Please do not send original documents. Send a clear, readable copy.

One (1) of the following:		**Two (2) of the following:**
• Colorado driver's license • Colorado ID • Temporary Colorado driver's license • Temporary Colorado ID **Proof of residency is not required if submitting a Colorado-issued ID.**	**OR**	**Minimum of one (1) ID from the group below -** • Out-of-state driver's license or ID • U.S. Passport or Passport Card • U.S. Military ID (copy of front and back) • Tribal ID **And a minimum of one (1) proof of residency from the group below -** • Proof of Colorado employment (paycheck stub/W-2/certified Colorado tax return) • Copy of an entire government-issued benefit letter (PERA, SSI, Disability, etc.) • Copy of a Colorado-issued certification (such as nursing, electrician, etc.) • Copy of a utility bill. All addresses on the bill must be in Colorado.

If you do not have the above documents, please contact the Registry at 303-692-2184 (ext. 3) to discuss other options.

i. All documents must be currently valid when received at the Registry.
ii. Damaged, expired, or tampered IDs are not valid.
iii. The address on the ID **does not** have to match the mailing address on the application.
iv. All IDs must be verifiable and have specific issue and expiration dates.
v. At least one document must show the patient's date of birth.
vi. Passports must include full photo page and the signed signature page. Passport cards must include copy of front and back.
vii. Proof of residency materials must be dated within 60 days of the date the Registry receives them, unless otherwise noted.
viii. As proof of Colorado employment, the W-2 or certified Colorado tax return must be for the most recent tax year and have a Colorado mailing address.
ix. Bills from telephone, electricity, water, trash, cable, or internet providers are considered valid and verifiable utility bills. Bills must include the organization name, logo and contact information.
x. All government benefit letters must include the issuing agency's logo and contact information; the patient's name and address; and an account or case number. Examples of acceptable benefit letters include PERA, Medicaid/Medicare, Food Stamps/Food Assistance, TANF, and Social Security.
xi. Certification documents must include the patient's Colorado address, be issued by a Colorado state agency and be dated within the last year.

8. **Non-refundable $35 application fee or Request for Fee Waiver/Tax Exempt Status form:**
The following application fee and fee waiver processes are effective for applications received January 1, 2012 or later.
   a. **To pay $35 application fee:** Make check or money order payable to CDPHE. We do not accept temporary checks. **Do not send cash.** Please write the patient's name on the payment. Make sure the form of payment is signed. The notary cannot sign the form of payment. The date of payment must be less than one (1) year old when received at the Registry. **All monies received by the Registry are nonrefundable.**
   b. **To request a fee waiver:** You must submit a Request for Fee Waiver/Tax Exempt Status form (#MMR1010) and a **certified** copy of a current Colorado tax return with your application packet. You may qualify for a fee waiver if your household income is at 185% of the Federal Poverty Level or less. The chart below indicates the annual household incomes, adjusted for family size, that qualify for a fee waiver.

Household incomes at 185% of 2013 Federal Poverty Guidelines*

Source: Federal Register, Vol. 78, No. 16, January 24, 2013, pp. 5182-5183.

# in Family	Annual Income
1	$ 21,257
2	$ 28,694
3	$ 36,130
4	$ 43,567
5	$ 51,005
6	$ 58,442
7	$ 65,879
8	$ 73,316
Each additional	$ 7,437

*Poverty guidelines are updated periodically in the Federal Register by the U.S. Department of Health and Human Services under the authority of 42 U.S.C. 9902(2)

9. Submit all items by mail or deliver to the Registry's drop-box. The Registry does not accept forms by fax or e-mail.

Mail To:

Application Processing
CDPHE
HSV-8608
4300 Cherry Creek Drive South
Denver, CO 80246-1530

Drop-Box:
Colorado Dept. of Public Health & Environment
710 S. Ash Street, Southeast Entrance
Open: Monday-Friday, 7:00 a.m. to 6:00 p.m.
The drop box is on the wall inside the first set of glass doors. Your paperwork must be in a sealed envelope. You will not receive a receipt. **If you wish to have a receipt, please mail in your paperwork by certified mail.**

Application Packet Checklist:

- ❑ The application is complete and accurate.
- ❑ The application was signed and dated by you and a notary.
- ❑ The dates of your signature and the notary's signature match.
- ❑ The physician certification is complete and accurate.
- ❑ The date of the physician's signature is current. Mail your application packet as soon as possible after your physician signs the physician certification.
- ❑ There are no areas on any of the forms where information has been written over, crossed out or white-out was used.
- ❑ You have included a clear copy of your valid Colorado ID.
- ❑ If you do not have a Colorado ID, you have included a clear copy of your ID and proof of residency.
- ❑ If included, all copies of utility or cable bills show both the "mail to" address and the "service" address. Both addresses must be in Colorado.
- ❑ You have made copies of all the documents you are sending to the Registry.
- ❑ You have included a form of payment or the Request for Fee Waiver/Tax-Exempt Status form, including a certified copy of your Colorado tax return.
- ❑ Submit your application packet for yourself. Do not allow anyone else to submit the paperwork for you.
- ❑ Send your application packet by certified mail to have proof of submission. Keep the mail receipt.

Questions can be sent by e-mail to medical.marijuana@state.co.us or by phone at 303-692-2184 (ext. 3).

Application Review Process:

1. **Initial Review:** The Registry reviews all applications against criteria described in the Application Instructions. The nonrefundable application fee, if included in the application packet, is deposited.
2. **Approved Application:** If an application packet is complete and has all supporting materials, a card is mailed.
3. **Rejected Application:** If an application packet is inaccurate or incomplete, the Registry processes the payment and keeps the submitted paperwork. A rejection letter detailing corrections needed is sent to the patient. With each rejection, patients are given 60 days to make corrections without paying additional application fees. Patients are given two (2) opportunities to submit corrections to the Registry.
4. **Approved Corrections:** When corrections are submitted to the Registry, they are reviewed for accuracy and completeness. If the application packet is complete after corrections, a card is mailed to the patient.
5. **Corrections Beyond 60-Days**: Patients who do not submit corrections within the 60-day window must submit a new application packet including a new physician certification and an additional $35 application fee.
6. **Denial:** The application is denied after the patient has submitted inaccurate or incomplete paperwork three times (the original application plus two correction attempts). The patient will have to wait six (6) months before re-applying for a Medical Marijuana Registration card, **if the application is denied**.
7. **Appeals:** If an application is denied, or the Registry suspends or revokes the patient's current registration card, a notice will be sent to the patient with details regarding the reason for denial, suspension or revocation. If the patient disagrees with a final decision from the Registry, the patient may send a letter to the Registry requesting an appeals hearing. The request for a hearing must be received by the Registry within thirty (30) calendar days from the date of the postmark on the notice.

For more information, please visit www.cdphe.state.co.us/hs/medicalmarijuana or call 303-692-2184.
The Registry is not affiliated with any privately operated club, organization, or dispensary.

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AP

STAFF ONLY

Evaluated

Data Entry 1

Data Verified

Finance

Data Entry 2

Card Printed

Corrections:

Application for Registration Card

Carefully complete the packet. Do not make corrections to the form.
See instructions on page 1. Proof of identity required with all forms.

☐ **New:** I have never had a Colorado Registry card. ☐ **Renewal:** I have been on the Colorado Registry before.

1. Social Security Number - -	**Section A: Patient Information (Required)** **The name on the form must match the legal name on your ID.**		
2. Last Name	3. First Name		4. Middle Initial
5a. Mailing Address	5b. Apartment/Suite #	6. City	
State **CO**	7. Zip Code	8. County	9. Date of Birth - -	10. Telephone Number ( ) -
11. E-mail Address (optional)*			12. Gender ☐ Male ☐Female

* By providing your e-mail address, you agree to receive communication from the Registry by e-mail.

Section B: Caregiver (Optional)

To designate a primary caregiver, form #MMR1012 Caregiver Acknowledgment must be submitted with the application.
Only homebound patients, or patients under age 18, may list both a caregiver and a Medical Marijuana Center.

13. Caregiver Last Name	14. Caregiver First Name	15. Date of birth - -

Section C: Medical Marijuana Center (Optional) -- Please complete information based on the retail name of the business (dba name) rather than the corporate or LLC name.

Only homebound patients, or patients under age 18, may list both a caregiver and a Medical Marijuana Center.

16. Medical Marijuana Center Name			17. Dept. of Revenue License #
18. Medical Marijuana Center Mailing Address			18a. Apartment/Suite #
19. City	State **CO**	20. Zip Code	21. Telephone Number ( ) -
22. Fax Number ( ) -	23. E-mail Address (optional)*		

I hereby certify that the above information is correct and complete.

23. Patient's Signature: ▶	24. Date Signed: (mm/dd/yyyy)

The signature and proof of identity of the above individual was subscribed and sworn to before me in

_____ County, Colorado on this _____day of _____, 20____.
(County name) (Day) (Month)

_____
(Notary's official signature)

_____
(Commission expiration date)

AFFIX NOTARY SEAL

Colorado Department of Public Health and Environment

Physician Certification Instructions

1. Complete the entire form, sign and date.
2. If you make a mistake on this form, please complete a new form. **Do not write over, white-out or cross-out information. This will void the form.**
3. Patients must have a **new physical exam each year** as part of their renewal process. Ensure the exam date reflects the most current patient information.
4. Please keep a copy of the form in the patient's medical record. To avoid fraud, the Registry verifies all physician signatures. You will receive a verification letter for patients in the months the Registry receives physician certifications with your signature.
5. Auto defaults:
    - If question #7 is incomplete or both boxes are selected, the auto-default response is "no."
    - If question #21 is incomplete, the auto-default response is "standard amount."
6. **Please do not fax or e-mail the form to the Registry.** The patient must submit the physician certification along with his or her complete Medical Marijuana Registry application packet.
7. This does not constitute a prescription for marijuana.
8. To sign the form, you must be an MD or DO with an active Colorado medical license. Physicians with conditions or restrictions on their licenses, or out-of-state licenses, are not accepted.
9. A copy of your current DEA certification must be on file with the Registry. If you have not already provided this, please fax a copy to 303-758-5182. If your DEA is not on file when we receive your patient's paperwork, it will be rejected.
10. **The Registry cannot accept paperwork on security paper that reads "VOID" when copied.**
11. Encourage patients to submit their application packets as soon as possible after you sign the physician certification. **The Registry rejects physician certifications that are more than 60 days old.**
12. The Registry has included in the application packet, for your review, **"Regulation 8: Physician requirements; reasonable cause for referrals of physicians to the Colorado Medical Board; reasonable cause for department adverse action concerning physicians; appeal rights."** For a link to the complete Board of Health rules, please visit our website www.cdphe.state.co.us/hs/medicalmarijuana.
13. You may contact the Registry at medical.marijuana@state.co.us or (303) 692-2184, if you have any questions.

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PC

Physician Certification

See instructions on page 1. Proof of identification required with all forms.

STAFF ONLY

_____
Evaluated

Corrections:

Patient Information

1. Last Name (as on ID)	2. First Name (as on ID)	3. Middle Initial	4. Date of Birth - -

5. What is the date of physical examination for the purpose of the medical marijuana recommendation? (mm/dd/yyyy) - -

6. Are you available to provide follow-up care? ☐ Yes ☐ No (No answer or both answered will default to 'Yes.')

a. If 'No', select one: ☐ Retiring ☐ Moving ☐ Other: _____

b. Date of change reflected in 6a: _____/_____/_____

7. In your opinion, is this patient homebound? ☐ Yes ☐ No (No answer or both answered will default to 'No.')

Physician Information

8. License Number DR -	9. Last Name	10. First Name	11. Middle Initial

12. Mailing Address

13. City	14. State	15. Zip Code

16. Telephone Number ( ) -	17. Fax Number ( ) -	18. E-mail Address (optional)

19. DEA Certification: The Registry requires a copy of your current DEA certification for their files. If you have not already provided this, **FAX a copy to 303-758-5182 to prevent delays in processing this application.**

Physician's Statement

20. The above-named patient has been diagnosed with and is currently undergoing treatment for the following chronic, debilitating medical condition:

☐ a. Cancer ☐ b. Glaucoma ☐ c. HIV or AIDS positive

or The patient has a chronic or debilitating disease or medical condition that produces one or more of the following and which, in the physician's professional opinion, may be alleviated by the medical use of marijuana.

☐ d. Cachexia***** ☐ e. Severe nausea***** ☐ f. Seizures*****
☐ g. Persistent muscle spasms***** ☐ h. Severe pain*****

***Etiology is required for these medical conditions, if known.**

Etiology:_____ **or** ☐ Etiology unknown.

21. **Plant Count:** (If unanswered or both selected, will default to standard amount)

☐ a. Standard amount 6 plants/2 ounces
☐ b. Increased amount: _____ plants/_____ ounces
c. Reason for increased plant count (required if 21b selected):

_____

22. Comments: (If no comments, the Registry recommends crossing through this area to prevent comments after your signature.) _____

_____

_____

I hereby certify that I am a physician duly licensed in good standing to practice medicine in Colorado, and that I have a bona fide physician-patient relationship with the above-named patient. I have assessed this patient's medical history and current medical condition. I conclude that this patient may benefit from the medical use of marijuana. I do not have a financial tie to a medical marijuana center. This assessment is not a prescription for the use of marijuana.

23. Physician's Signature: ▶	24. Date Signed: (mm/dd/yyyy)

Regulation 8: Physician requirements; reasonable cause for referrals of physicians to the Colorado Medical Board; reasonable cause for department adverse action concerning physicians; appeal rights

A. **Physician requirements.** A physician who certifies a debilitating medical condition for an applicant to the medical marijuana program shall comply with all of the following requirements:

1. **Colorado license to practice medicine.** The physician shall have a valid, unrestricted Colorado license to practice medicine, which license is in good standing.

   a. For the purposes of certifying a debilitating medical condition of an applicant and recommending the use of medical marijuana for the medical marijuana program, "in good standing" means:

      i. The physician holds a doctor of medicine or doctor of osteopathic medicine degree from an accredited medical school;

      ii. The physician holds a valid license to practice medicine in Colorado that is not restricted or conditioned, unless the physician has received written confirmation from the Colorado medical board that the physician's scope of practice does not preclude recommending medical marijuana; and

      iii. The physician has a valid and unrestricted United States Department of Justice federal drug enforcement administration controlled substances registration.

2. **Bona fide physician patient relationship.** A physician who meets the requirements in subsection A.1 of this Regulation 8 and who has a bona fide physician-patient relationship with a particular patient may certify to the state health agency that the patient has a debilitating medical condition and that the patient may benefit from the use of medical marijuana. If the physician certifies that the patient would benefit from the use of medical marijuana based on a chronic or debilitating disease or medical condition, the physician shall specify the chronic or debilitating disease or medical condition and, if known, the cause or source of the chronic or debilitating disease or medical condition.

   a. "Bona fide physician-patient relationship", for purposes of the medical marijuana program, means:

      i. A physician and a patient have a treatment or counseling relationship, in the course of which the physician has completed a full assessment of the patient's medical history and current medical condition, including an appropriate personal physical examination;

      ii. The physician has consulted with the patient with respect to the patient's debilitating medical condition before the patient applies for a registry identification card; and

      iii. The physician is available to or offers to provide follow-up care and treatment to the patient, including but not limited to patient examinations, to determine the efficacy of the use of medical marijuana as a treatment of the patient's debilitating medical condition.

   b. A physician making medical marijuana recommendations shall comply with generally accepted standards of medical practice, the provisions of the medical practice act, § 12-36-101 *et seq.* , C.R.S, and all Colorado Medical Board rules.

   c. The "appropriate personal physical examination" required by paragraph A.2.a.i of this Regulation 8 may not be performed by remote means, including telemedicine.

3. **Medical records.** The physician shall maintain a record-keeping system for all patients for whom the physician has recommended the medical use of marijuana. Pursuant to an investigation initiated by the Colorado medical board, the physician shall produce such medical records to the Colorado Medical Board after redacting any patient or primary caregiver identifying information.

4. **Financial prohibitions.** A physician shall not:

   a. Accept, solicit, or offer any form of pecuniary remuneration from or to a primary caregiver, distributor, or any other provider of medical marijuana;

   b. Offer a discount or any other thing of value to a patient who uses or agrees to use a particular primary caregiver, distributor, or other provider of medical marijuana to procure medical marijuana;

   c. Examine a patient for purposes of diagnosing a debilitating medical condition at a location where medical marijuana is sold or distributed; or

d. Hold an economic interest in an enterprise that provides or distributes medical marijuana if the physician certifies the debilitating medical condition of a patient for participation in the medical marijuana program.

B. **Reasonable cause for referral of a physician to the Colorado Medical Board.** For reasonable cause, the department may refer a physician who has certified a debilitating medical condition of an applicant to the medical marijuana registry to the Colorado Medical Board for potential violations of sub-paragraphs 1, 2, and 3 of paragraph A of this rule.

C. **Reasonable cause for department sanctions concerning physicians.** For reasonable cause, the department may sanction a physician who certifies a debilitating medical condition for an applicant to the medical marijuana registry for violations of paragraph A.4 of this rule. Reasonable cause shall include, but not be limited to:

1. The physician is housed onsite and/or conducts patient evaluations for purposes of the medical marijuana program at a location where medical marijuana is sold or distributed, such as a medical marijuana center, optional grow site, medically infused products manufacturer, by a primary caregiver, or other distributor of medical marijuana.

2. A physician who holds an economic interest in an entity that provides or distributes medical marijuana, such as a medical marijuana center, an infused products manufacturer, an optional grow site, a primary caregiver, or other distributor of medical marijuana.

3. The physician accepts, offers or solicits any form of pecuniary remuneration from or to a primary caregiver, medical marijuana center, optional grow site, medically infused product manufacturer, or any other distributor of medical marijuana.

4. The physician offers a discount or any other thing of value, including but not limited to a coupon for reduced-price medical marijuana or a reduced fee for physician services, to a patient who agrees to use a particular medical marijuana center, primary caregiver, or other distributor of medical marijuana.

D. **Sanctions.** For reasonable cause, the department may propose any of the following sanctions against a physician:

1. Revocation of the physician's ability to certify a debilitating medical condition and recommend medical marijuana for an applicant to the medical marijuana registry; or

2. Summary suspension of the physician's ability to certify a debilitating medical condition or recommend medical marijuana for an applicant to the medical marijuana registry when the department reasonably and objectively believes that a physician has deliberately and willfully violated section 14 of article xviii of the state constitution or § 25-1.5-106, C.R.S. and the public health, safety and welfare imperatively requires emergency action.

E. **Appeals.** If the department proposes to sanction a physician pursuant to paragraph c of this rule, the department shall provide the physician with notice of the grounds for the sanction and shall inform the physician of the physician's right to request a hearing.

1. A request for hearing shall be submitted to the department in writing within thirty (30) calendar days from the date of the postmark on the notice.

2. If a hearing is requested, the physician shall file an answer within thirty (30) calendar days from the date of the postmark on the notice.

3. If a request for a hearing is made, the hearing shall be conducted in accordance with the state administrative procedures act, § 24-4-101 et seq. , C.R.S.

4. If the physician does not request a hearing in writing within thirty (30) calendar days from the date of the notice, the physician is deemed to have waived the opportunity for a hearing.